

To: Ms. Angela Sherwin, Principal Policy Associate, OHIC
From: Al Kurose, M.D., President and CEO, Coastal Medical
Re: Regulation 2 amendments

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MAY 01 2011

Health Insurance
Commissioner

This correspondence is submitted in response to OHIC's invitation for public comment on proposed amendments to regulation 2. I am responding both as President and CEO of Coastal Medical, and as an adult primary care physician with 20 years of experience in community based office practice. Coastal is a predominantly primary care organization that provides care to 105,000 Rhode Islanders in 16 NCQA Level 3 medical home offices across the state.

I strongly support the proposed amendments to Regulation 2. The OHIC affordability standards and CSI-RI, Rhode Island's all-payer Patient Centered Medical Home (PCMH) Initiative, have both provided crucial support to Coastal Medical's efforts to achieve the "Triple Aim" for our population of patients: improved population health, improved patient experience of care, and improved cost efficiency.

As is well known to OHIC, it was shown in 2000 that the global cost of healthcare for a state's Medicare population was lower if the number of primary care providers per capita was higher. Similarly, it was demonstrated that quality measures for the Medicare population of a state were more favorable if the number of primary care providers per capita was higher. This means investments that help to successfully attract and retain primary care providers should improve the quality of health care in Rhode Island and also make care more affordable.

Data is now flowing in from across the country demonstrating that coordinated care using a PCMH model of care has been successful in meeting the "Triple Aim" goals. The quality of care is improved, patients are more satisfied, and cost is reduced. And, as reported by Dr Ed Wagner in his IHI Summit keynote address last month, primary care providers are also more satisfied, and some are choosing to stay in a profession they were getting ready to leave.

At CSI-RI, we are still waiting for our utilization analysis, but the practices have demonstrated clear improvement in quality metrics using the PCMH model. And the docs are happier in the new model of care. There is agreement without exception at CSI that electronic medical records (EMR's) are an essential tool in any medical home.

At Coastal, our experience with CSI-RI (we have two clinical offices in the project) has taught many lessons we have applied in all Coastal offices. Learning at CSI has guided our practice transformation work and shaped our strategy for the future. **And the Affordability Standards have been a key driver in bringing payers to the contract negotiating table with the willingness to provide the support we need to drive PCMH practice transformation.**

In November of 2010, Coastal signed a groundbreaking contract with BCBSRI that provides support for coordination of care using nurse care managers (NCM's), medication therapy management provided by clinical pharmacists in the medical home, data analysts, enhanced patient access to care on weekends with a new Saturday clinic, and interoperability through connection to Lifespan's private Health Information Exchange (HIE). The contract also includes incentives for achieving clinical quality targets and support for behavioral health providers "co-

located” in medical home offices. And Blue Cross has provided Coastal with meaningful training support by retaining Transformed, a consultant with a national reputation for excellence in supporting practice transformation. **This agreement could not have been achieved without the shared learning at CSI and the impetus of the Affordability Standards to bring the payer to the table.**

What have we achieved in the first full quarter with the new BCBSRI contract at Coastal? We have hired 8 nurse care managers and they are working in our offices. We are getting close to setting a go-live date for a fully functional connection of our EMR with the Lifespan HIE. In the first quarter of 2011, we provided 246 adult and 1,096 pediatric visits *on the weekend in our offices*. And in our adult Saturday clinic, we counted **46 patients in the first quarter that would have had to be seen in an emergency room** if the Saturday clinic was not available (ie. We had 46 so-called “ER diversions”). We achieved *every* clinical quality target for the first quarter. The docs are working hard to accommodate all the new changes, they are generally happy, and they are making a little more money. Patients are thrilled to receive new services that were not available before. We don’t yet have bottom line documentation of improved affordability based on a global budget, but the documentation of ER diversions is an encouraging first piece of data. **None of this would have happened without CSI and the Affordability Standards.**

Our next area of focus at Coastal will be to improve communication with hospitals and enhance the safety of care transitions. In numerous discussions at the Primary Care Physician Advisory Council to the Director of Health, there has been uniform agreement that communication between most hospitals and physicians in RI – excepting at South County Hospital – is problematic. The amendments to Regulation 2 offer help with this problem.

In closing, **I strongly support the proposed amendments to Regulation 2.** In order to achieve the “Triple Aim” of improved population health, improved patient experience of care, and reduced healthcare costs, we will need:

- Continued financial support of primary care through the Affordability Standards
- Continued support for CSI-RI (RI’s PCMH Initiative)
- Financial support for practices working to choose, purchase, and implement an EMR (All Coastal practices have a fully functional EMR, but many other primary care practices do not.)
- Cost effective contracting with hospitals that incents improved communication and coordination of care.

It is worth noting that RI is gaining progressive national recognition as a leader in the PCMH movement. **RI is ranked #1 in the country with respect to the number of providers per capita working in a NCQA recognized patient centered medical home. The constructs supported by the amendments to Regulation 2 are part of the reason for that success.**

There is reason to be optimistic that we will soon demonstrate that care is becoming more affordable in RI, and that we will be successful as a statewide community in meeting the challenge of the Triple Aim. But there is also much hard work to be done, and sufficient support for primary care will remain critically important both to our success in these efforts, and to our ability to attract and retain the next generation of primary care physicians.

Respectfully submitted by Al Kurose, M.D. on April 30, 2011

American Academy of Pediatrics

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Rhode Island Chapter

Rhode Island Chapter of the AAP
PO Box 20365
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April 30, 2011

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Dear Commissioner Koller,

I am writing on behalf of the more than 200 pediatricians in this state in strong support of the proposed amendments to Regulation 2. The work represented in these regulations provides the financial and system support that pediatricians need in order to care for our patients.

The Affordability Standards are an innovative method for improving the healthcare of pediatric patients and providing more resources for pediatricians. The plan for specific payment strategies for Patient Centered Medical Home initiatives, electronic health records, primary care services and hospital contracting is the cornerstone for improving healthcare in Rhode Island.

Therefore, the Rhode Island chapter of the American Academy of Pediatrics writes in support of Regulation 2 which supports these key systems changes and support.

Sincerely,

Patricia Flanagan, MD FAAP

A handwritten signature in black ink, appearing to read "Patricia Flanagan", with a stylized flourish at the end.

President

HealthInsInquiry - Input for OHIC Public Comment on OHIC Regulation 2

From: Laura Adams <LAdams@riqi.org>
To: "healthinsinquiry@ohic.ri.gov" <healthinsinquiry@ohic.ri.gov>
Date: 5/3/2011 3:54 PM
Subject: Input for OHIC Public Comment on OHIC Regulation 2
CC: "Christopher Koller" <ckoller@ohic.ri.gov>

Office of the Health Insurance Commissioner
 1511 Pontiac Avenue, Building 69-1
 Cranston, RI 02920
 Attention: Herbert W. Olson, Legal Counsel

We appreciate this opportunity to provide public comment on the Proposed Amendments to the OHIC Regulation 2 – Powers and Duties of the Office of the Health Insurance Commissioner.

Comment #1:

Section 9: Affordable Health Insurance; section (d)(C)(1)

We strongly support the inclusion of the demonstration of “meaningful use” in the criteria for provider eligibility for health insurer support and incentives for the adoption of electronic health records. We recommend that the OHIC consider specifying the demonstration of “meaningful use” **at each of the three phases**, as defined by the Centers for Medicaid and Medicare. At this point, the criteria for Phase I have been released and the criteria for the other two phases have yet to be finalized.

Comment #2:

Section 9: Affordable Health Insurance; section (d)(C)(2)(II)

We strongly support the inclusion of enrollment in the RI Regional Extension Center in the criteria for provider eligibility for health insurer support and incentives for the adoption of electronic health records.

We recommend inserting the phrase “and actively pursue advancement toward “meaningful use”” immediately after the word “Enroll”, such that the first sentence of this section reads, “Enroll and actively pursue advancement toward “meaningful use” in the Rhode Island Regional Extension Center...”

Comment #3:

Section 9: Affordable Health Insurance; section (d)(D)

Regarding terms to be included in health insurer contracts with hospitals in Rhode Island, we recommend that OHIC consider including clauses regarding the achievement of “meaningful use” and enrollment in currentcare, much in the same way that it is described in proposed criteria (with our recommended edits) for primary care provider eligibility for health insurer support and incentives for the adoption of electronic health records.

Comment #4:

In reference to the preparation of future draft amendments, we recommend that once currentcare, RI’s statewide health information exchange, is rolled out to providers, consideration is given to including in the criteria for provider eligibility for health insurer support and incentives for the adoption of electronic health records **the use** of currentcare in clinical care delivery. At this stage of the system development, it is appropriate to limit the currentcare criteria to enrollment of patients, but once the system becomes available, actual use should be considered as a criterion.

Thank you very much for the opportunity to comment.

Best regards,

Laura Adams

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Herbert W. Olson
Legal Counsel
Office of the Health Insurance Commissioner
1151 Pontiac Avenue, Building 69-1
Cranston, RI 02920

Health Insurance
Commissioner

Re: Proposed Amendment to Regulation 2 – Powers and Duties of the Office of
the Health Insurance Commissioner, Section 9 Affordable Health Insurance

Dear Mr. Olson:

I am writing on behalf of UnitedHealthcare of New England, Inc. and UnitedHealthcare Insurance Company (“UnitedHealthcare”) in response to the Notice of Proposed Amendment to Regulation 2 issued by the Office of the Health Insurance Commissioner (OHIC) (the “Proposed Amendment”). For the reasons expressed below, UnitedHealthcare believes the Proposed Amendment materially overstates the statutory authority of the OHIC. Therefore, UnitedHealthcare urges the OHIC to withdraw the Proposed Amendment in its entirety.

First, UnitedHealthcare wants to emphasize that it continues to work to provide quality, affordable health care coverage to Rhode Island employers, employees, and their families. As part of its mission to help people live healthier lives, UnitedHealthcare offers innovative product designs, wellness programs, and disease management resources to assist its members in making good decisions about their health care choices.



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Along these lines UnitedHealthcare looks to collaborate in community initiatives that are aimed at improving the delivery of health care and recognize the importance of primary care. UnitedHealthcare’s engagement in the Chronic Care Sustainability Initiative (CSI) is one example of its involvement in a statewide effort aimed at supporting primary care and improving the health of our citizens while looking to address the increasing costs in our health care system.

In addition, over the past several years, UnitedHealthcare has been actively involved in a number of discussions in the General Assembly regarding ideas on how to improve our state's health care system. The important decisions relative to comprehensive reform of our state's health care system reside with the legislature. UnitedHealthcare has been and continues to be concerned with many important public policy decisions being made by the OHIC without the express legislative intent of the General Assembly.

The Proposed Amendment seeks to provide the OHIC with authority to require health insurers to participate in certain specific quality and affordability initiatives adopted by OHIC and to impose penalties on insurers for failing to fully meet the terms of participation in those initiatives. The Proposed Amendment also seeks to provide the OHIC with authority to impose new review criteria for reviewing rate submissions based on a variety of factors set forth in Section 9. Proposed Amendment at § 9(b). The Proposed Amendment would permit the OHIC to consider whether the health insurer's products are affordable and whether an "insurer employs provider payment strategies to enhance cost effective utilization . . ." Proposed Amendment at § 9(d)(iii). The Proposed Amendment then sets forth four non-exclusive payment strategies, including how insurers enter into contracts with providers. *See id.* at § 9(d)(iii)(A-D).

The OHIC has limited jurisdiction to approve filed rates. Agencies, such as the OHIC, "are creations of the legislature, they have no inherent power in and of themselves to promulgate rules and regulations, they do so with authority that is 'limited and defined by the statute conferring the power'" *State of Rhode Island v. Patterson*, 2002 R.I. Super. LEXIS 152 at *11-12 (R.I. Super. Nov. 20, 2002) (citations omitted). The standards and criteria to which the OHIC must adhere in evaluating filed rates are fixed by statute. *See e.g.*, R.I.G.L. §§ 27-41-27.2, 27-18-54, 27-20-6, 27-19-6. Similarly, the powers of the OHIC are limited by statute and do not include evaluating rates based on factors separate and apart from those set by statute. *See e.g.*, R.I.G.L. § 42-15.5-3. In fact, there is presently proposed legislation to expand the powers of the OHIC to those set forth in the Proposed Amendment. Senate Bill 0870 introduced on April 14, 2011 seeks to amend R.I.G.L. § 42-15.5-3 to permit the OHIC to, among other things, "establish benchmark standards" related to "payment methodologies" and as to "contracts between payers and providers" "in connection with the approval or modification of any rate insurance filing."

The legislature has also debated some of these same issues in prior legislative sessions and to date has failed to reach consensus on them. *See e.g.*, 2011 House Bill 5276 and 2010 House Bill 7544 (Medical Home); 2010 House Bill 7560 and 2010 Senate Bill 2552 (Payment Reform; Primary Care Reimbursement) and 2011 Senate Bill 0874 and 2010 Senate Bill 2579 (designation of a primary care physician).



Accordingly, OHIC is exceeding its present legislative authority by seeking to enact the Proposed Amendment and the Proposed Amendment “would undermine the integrity and structure of our state government because it would allow every government official to act as his own mini-legislature, cashiering those laws he or she dislikes, is ignorant of or misinterprets, and instead molding the law to be whatever the government official claims it to be.” *Romano v. Retirement Board of the Employees’ Retirement System of Rhode Island*, 767 A.2d 35, 43 (R.I. 2001). For this reason also, the Proposed Amendment should be withdrawn until such time as the legislature has provided clear and explicit regulatory authority to OHIC.

Further, the OHIC’s inclusion of considering “payment strategies” and the four specific terms explicitly set forth in the Proposed Amendment are neither grounded in statute nor are actuarially appropriate criteria to assess whether filed rates are inadequate or excessive. The first “payment strategy” is to impose on insurers a mandatory consecutive 1% yearly increase in primary care spending for a period of five years.¹ The OHIC has no statutory authority to impose this burden on insurers in order for their filed rates to be approved. Similarly, mandatory financial support in the expansion of the Patient Centered Medical Home collaborative and provider adoption of electronic health records are completely irrelevant criteria to the authority of the OHIC to approve or reject filed rates.

Finally, the Proposed Amendment demands that insurers include additional incentives to hospitals in participating hospital agreements. The Proposed Amendment explicitly sets forth six terms to be included in such agreements and, even more troubling, a catch-all provision for the OHIC to include any term it deems appropriate. This provision essentially would permit the OHIC to draft insurer agreements with its hospitals and then permit the OHIC to refuse to approve filed rates if the insurer or the hospital did not agree to the terms. The OHIC has no legal authority to disapprove actuarially sound rates because it may not necessarily approve of the contracts hospitals freely enter into with insurers.

In sum, the actuarial standards and methodology to develop sound rates for health insurance products are well-established and clearly defined. The Proposed Amendment, would, for all practical purposes, suggest that rates developed in accordance with generally accepted actuarial principles could *never* be approved.

¹ UnitedHealthcare considers the implementation of these “payment strategies,” which include additional insurer costs, to be mandatory for its rates to be approved. While the Proposed Amendment states that the Commissioner “may” consider the payment strategies set forth in the Proposed Amendment, the Concise Explanatory Statement of the Proposed Amendment on the OHIC’s website states that implementation of these payment strategies “will” be considered by the Commissioner.



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The OHIC not only lacks the statutory authority to re-write the criteria by which health insurance rates shall be developed and evaluated (as evidenced by Senate Bill 0870) but, in addition, the criteria set for in the Proposed Amendment would lead to rates which are, at best, actuarially unsound. At worst, the criteria would, if implemented, jeopardize the long-term financial stability of the local health insurance market.

For all the above reasons, UnitedHealthcare urges the OHIC to withdraw the Proposed Amendment to Regulation 2 in its entirety. Should the OHIC choose to promulgate this regulation in whole or in part, UnitedHealthcare requests the OHIC, in accordance with R.I.G.L. § 42-35-3(a)(2), issue a statement setting forth the reasons for overruling the considerations set forth herein.

Very truly yours,



Joseph L. Clasen





Rhode Island
Primary Care Physician Advisory Committee

*"Advising the Rhode Island Department of Health on programmatic
and policy issues that support primary care in Rhode Island."*

Elizabeth Lange, MD
RIAAP Representative
PCPAC Chairperson

Gregory Allen, Jr., DO
RISOPS Representative

David Ashley, MD
RIAAP Representative

Munawar Azam, MD
Adult Health Associates

Thomas Bledsoe, MD
RIACP Representative

Stanley Hoyt Block, MD
Health Centers Representative

Jeffrey Borkan, MD, PhD
Memorial Hospital of RI

David Bourassa, MD
Health Centers Representative

Mark Braun, MD
Woodridge Medical Associates

Denise Coppa, PhD, RNP
RI NPC Representative

Nitin Damle, MD
RIACP Alternate

Charles Eaton, MD, MS
Memorial Hospital of RI

Fadya El Rayess, MD, MPH
Health Centers Alternate

Patricia Flanagan, MD
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Arnold Goldberg, MD
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Ellen Gurney, MD
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Cynthia Holzer, MD, CMD
RIGS Representative

Kathryn Koncsol, MD
*Large Group Practice
Representative*

G. Alan Kurose, MD
*Large Group Practice
Representative*

Anne Neuville, RNP
RI NPC Alternate

Albert J. Puerini, Jr., MD
RI Primary Care Physicians Corp.

Patrick Sweeney, MD, PhD, MPH
RI ACOG Representative

Richard Wagner, MD
RI APA Representative

May 3, 2011

Dear Health Insurance Commissioner,

As Chair of the Rhode Island Department of Health's Primary Care Physician Advisory Council, I write on behalf of our committee members as well as all of Rhode Island's primary care providers to support the proposed amendments to Regulation 2.

The "Affordable Health Insurance" standards represent a very supportive policy change for primary care. As is well known, the cornerstone of healthcare reform rests on a strong primary care foundation. The innovative Affordability Standards fortify this bedrock by providing support for electronic health record acquisition, medical home initiatives, primary care payment reform and cost effective contracting with hospitals. The Rhode Island primary physicians and providers are actively engaging in the practice transformations that are required by healthcare and payment reform. We are all focused on the goal of better health for Rhode Island's citizens as well as reduced healthcare costs.

The proposed amendments to Regulation 2 support this goal and will give the primary care community the resources it needs to achieve these important changes. Therefore, the primary care medical community enthusiastically endorses this regulatory change.

Sincerely,

Elizabeth B. Lange MD

Elizabeth B. Lange, MD FAAP
Chair, Primary Care Physician Advisory Council



Psychological Centers, Inc.

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May 4, 2011

Office of the Health Insurance Commissioner
1511 Pontiac Avenue
Building 69-1
Cranston RI 02920

Attention: Herbert W. Olson, Legal Counsel
Re: Proposed Amendments to Regulation 2- Powers and Duties of
the Office of the Health Insurance Commissioner

Commissioner Koller,

When the individual occupying a prominent and powerful role is particularly well considered, the difficulty of evaluating the value of his or her position can be particularly complicated. For that reason, it is especially incumbent upon Rhode Islanders to be thoughtful and specific about the powers and duties of the Office of the Health Insurance Commissioner, which happens to be inhabited currently by a widely respected, remarkably effective Commissioner.

Regarding the Office, its value is inherent and unique in its explicit statutory obligation to serve all critical stakeholders in health care, including insurers, consumers (and purchasers), providers, and the state and public good (through encouragement of the quality and efficiency of health care delivery and outcomes), by promoting the greatest possible efficiency, quality, and access to appropriate and affordable services in the context of the health care "system" as a comprehensive entity.

The critical nature of this role cannot be overstated given the idiosyncrasies, importance, and cost of health care as a commodity and health insurance as a market. Unlike most markets, value-based purchasing and supply-demand economics do not apply in straightforward fashion to health care. Health care is variously considered and treated as a right, a public and personal good to be maximized, a public utility or public service maintained in the interest of the State, a personal benefit to be accessed according to individual consumer inclinations rather than accurate indications of need, and a luxury to be accessed as convenient and affordable. As such a large and growing portion of our state and national spending and economic sector, health care hugely and pervasively affects our social functioning. Yet decision making is made by individuals without adequate influence of public (or personal) outcomes; by payers based on influence and control rather than public good (or too often, their own best interest- as Alan Greenspan could now attest); by providers based on short term contingencies rather than cost-effectiveness; and by regulators based on distinct and limited perspectives and responsibilities.

Accordingly, having one position with the authority and responsibility to promote effective, affordable care for all from the perspective of the general public welfare is essential for improving the possibility of getting it, or at least getting something more like it.

For that reason, the proposed amendments to the regulation governing the powers and duties of the Office of the Health Insurance Commissioner are specifically important to support. The goals of the amendments, to increase the Commissioner's ability to promote cost-effectiveness by reducing avoidable hospitalization, emergency room utilization, and contain premium increases through strategies of supporting effective primary care and improving benefit design, are essential for the viability of health care as a public good.

To achieve these goals, the Commissioner must have adequately specified responsibility and power to influence all participants in the health care system toward the most efficient and generally (rather than individually) beneficial service design, provision, and use.

Because of the anomalies that cause the greatest impediment to decision making in health care financing and management, cost-effective contracting with hospitals, creative and cost-effective payment reform (more broadly, design and management of incentives influencing all participants in the health care enterprise), communication and shared responsibility across stakeholders, and public accountability (vs. proprietary market forces alone, without regulation for general public welfare) are especially necessary domains about which the Commissioner must be able to exert adequate oversight and influence. These are exactly the powers and duties addressed in the proposed amendments.

For these reasons, as a small business purchaser, efficiency and outcome-focused health care provider, individual consumer, and health care policy advocate, I extremely strongly support the proposed amendments and encourage their adoption and implementation as fully and rapidly as is expedient.

Sincerely,

Paul Block, Ph.D.
Director, Psychological Centers
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Paul.Block@PsychologicalCenters.com



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MAY 04 2011

Health Insurance
Commissioner

May 4, 2011

Mr. Christopher F. Koller
Health Insurance Commissioner
Office of Health Insurance Commissioner
1511 Pontiac Avenue
Cranston, RI 02920

Dear Mr. Koller,

Thank you for this opportunity to comment on the proposed amendments to the Office of Health Insurance Commissioner Regulation 2.

The Memorial Hospital of Rhode Island supports the proposed amendments which enhance the role of Primary Care physicians in the Rhode Island health care system. We operate an integrated health care delivery system and strongly believe in providing the right healthcare at the appropriate level of service. This can be best done through population based care management, which is facilitated by Primary Care physicians. The amendments to the regulations which tie subscribers to Primary Care physicians are necessary to do population based care management in the commercial population. Additionally, we support the Patient Centered Medical Home Initiative, as we are a leader in the academic research in this area.

However, we do oppose section (D)(2), which limits rate increases for hospital services to CMS price indexes. We oppose this because it effectively locks into place the current inequities in commercial payments to hospitals, as documented in the Office of Health Insurance Commissioner's report "Variations in Hospital Payment Rates by Commercial Insurers in Rhode Island" issued January, 2010. This report showed that, on a case mix adjusted basis, the hospitals which we compete against are paid nearly 12% more than Memorial for commercially insured inpatients. State healthcare policy makers should not assume that Memorial can long survive being paid less than the system hospitals we compete against for the same services.

We believe that these inequities could be eliminated through individual negotiations and transparency, as opposed to ridged caps on individual hospital increases. The "Maxicap" methodology in the Prospective Reimbursement system used in past years in Rhode Island provides a better model for cost containment. In this model, an overall "Maxicap" on statewide hospital increases is negotiated between the hospitals and the payers. Each individual hospital then negotiates its reimbursement with the payers freely, with the overall statewide increase limited to the statewide "Maxicap" negotiated increase. This

provides each hospital with the ability to negotiate its own increase based on its needs, while capping the statewide increase.

We also believe that all payers need to be responsible to pay their share of Medical Education costs. The Alpert Medical School at Brown University is a critical part of the health care system in the state. Memorial is the Center for Primary Care and Prevention for the medical school. The Family Medicine program at Memorial has long been one of the leading Family Medicine programs in the nation. Currently, the program has taken a national leadership role in research on Patient Centered Medical Home. As a part of our medical education program, Memorial operates the Family Medicine Center and the Internal Medicine Center on our main campus. These two centers provided 30,000 primary care visits, of which 45% of which were provided to Medicaid and Rite Care enrollees and 10% to patients with no insurance. Medical education funding supports the provision of primary care services in Pawtucket. It is critical that commercial insurers support the medical school by paying their share of Medical Education costs.

Memorial provides an integrated comprehensive system of care throughout the continuum, from primary care to inpatient to rehabilitation to home care to outpatient services. We can only continue to operate this network if we receive fair reimbursement for our services. We believe that our system is cost effective and provides high quality care to all, regardless of insurance status. We ask that state policy makers look to the value Memorial provides to our service area and put into place policies that fairly reimburse the hospital for those services.

Thank you once again for this opportunity to comment on the proposed regulations.

Sincerely,

Michael J. Ryan
Senior Vice President, Finance



May 4, 2011

Christopher F. Koller
Health Insurance Commissioner
1511 Pontiac Ave., Building # 69, First Floor
Cranston, RI 02920

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MAY 04 2011

Health Insurance
Commissioner

Dear Commissioner Koller,

I write today on behalf of the Rhode Island Health Center Association (RIHCA) and its members, Rhode Island's ten community health centers, in response to your invitation for comments on the proposed amendments to OHIC Regulation 2 - Powers and Duties of the Office of the Health Insurance Commissioner. I would like to comment specifically on the proposed additional regulations in Section 9(d)(iii)(B) and (C), relating to the patient centered medical home initiative and an electronic health record incentive payment.

RIHCA generally supports, as we have in the past, OHIC's primary care spend initiatives, and today writes in support of the proposed regulations, with some small but significant proposed changes. The community health centers are very supportive of the Health Insurance Commissioner's focus on increasing spending on primary care as a proportion of overall health care. This is good policy and a good way to help control health costs. Rhode Island's ten community health centers are a critical element in the state's health care landscape.

Serving over 120,000 Rhode Islanders annually, the community health centers provide comprehensive, high-quality primary and preventive care to some of Rhode Island's most vulnerable populations. In a state with no county health departments and no publicly run health clinics, Rhode Island's community health centers are the de facto public health infrastructure for primary care. The community health centers are acutely aware of the need for accessible, affordable primary care in Rhode Island, and your office's efforts to support primary care in the state are much appreciated.

Primary Care Medical Home

The proposed regulations call for the Health Insurance Commissioner to convene a collaborative, supported by the insurers, to develop a payment system for insurers to pay *select* patient centered medical homes for providing care coordination. OHIC Proposed Reg. 2, § 9(d)(iii)(B)(1) (emph. added). RIHCA supports the multiple state-wide efforts to bring the patient centered medical home (PCMH) model of care to practices throughout Rhode Island. RIHCA has been on the CSI-RI steering committee from the start, and one of our health centers is a practice included in CSI-RI. In addition, all of the community health centers participate in the Rhode Island Chronic Care Collaborative and many are participating in Beacon. Many of our community health centers are pursuing certification as a medical home through NCQA. RIHCA believes the

medical home model of care is good for patients, good for practices and good for state health policy.

We also think that it is important that any new programs developed to promote this model of care, and any further expansion of current programs, include any practice that meets a specified list of criteria. That is, expansion and development of medical home programs should be an open and inclusive process. In addition, once evaluation data is available on the pilot program, and assuming those data reflect achievement of goals relating to both better health outcomes and cost reduction, we would like to see CSI-RI expand state wide, and to include all practices that meet certain objective criteria. The medical home model of care is the wave of the future, and we hope that OHIC, through the primary care spend and other initiatives, helps promote this model through an inclusive process. This proposed regulation could be the next step in that direction, and to that end we wholeheartedly applaud it.

However, one word in § 9(d)(iii)(B)(1) gives us pause: "select". It is imperative that this not signal the intent to continue a closed process to hand-pick the next set of expansion practices. For this reason, **we recommend that the word "select" be replaced by the word "qualifying"**. This would indicate instead of the potential of a non-inclusive process, that the expansion of a medical home model in Rhode Island is intended to be open to those practices that meet a specified list of criteria.

Electronic Health Record Incentive Payment

In the proposed amendments to OHIC Regulation 2, § 9(d)(iii)(C) would require insurers to provide incentive payments to providers who are implementing electronic health records and meeting meaningful use requirements. We generally support this provision, with one reservation described below.

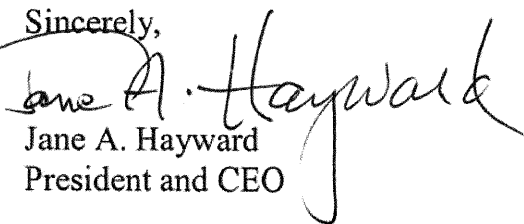
As the community health centers well know, electronic medical records are useful, and expensive to implement. Financial incentives are an important motivator and facilitator as practices decide when and how to implement EHRs.

Within a year, we expect that all of our community health centers will have implemented EHRs, and be well on their way to attaining meaningful use; many are there already. The community health centers have voluntarily participated in a number of programs, including CurrentCare and Beacon. In the case of the community health centers, at least, the additional requirements in § 9(d)(iii)(C)(2) are unnecessary to encourage meaningful use. Because it appears that incentives for meaningful use from the insurers is the purpose of this section of the proposed regulation, **we support § 9(d)(iii)(C) with the recommendation to omit paragraph (2) and the additional requirements therein.**

Thank you very much for taking a leadership role in controlling increasing health care costs and in promoting the importance of primary care in Rhode Island. RIHCA looks forward to working together with OHIC as we address the same concerns in the coming years.

Sincerely,

Jane A. Hayward
President and CEO

A handwritten signature in black ink, reading "Jane A. Hayward". The signature is written in a cursive style with a large, sweeping initial "J" and "H".

VIA E-MAIL and HAND DELIVERY

May 4, 2011

Herbert W. Olson
Legal Counsel
Office of the Health Insurance Commissioner
1151 Pontiac Avenue, Building 69-1
Cranston, RI 02920

RE: Proposed Amendments to Regulation 2 – Powers and Duties of the Health Insurance Commissioner

Dear Mr. Olson:

On behalf of Blue Cross & Blue Shield of Rhode Island (“BCBSRI”), I am writing to provide our comments regarding the proposed amendments to Regulation 2.

As a preliminary matter, BCBSRI supports many of the policy objectives that the Commissioner is trying to achieve through the proposed amendments. We have been an avid supporter of primary care, patient centered medical home programs, electronic medical records, and quality based hospital payments, all with the goal of achieving high quality and affordable health insurance coverage. We have actively participated in the work groups and related programs established by the Commissioner by dedicating both staff and financial resources to the laudable goals of the Commissioner in decreasing costs and improving quality of care for Rhode Islanders. We have done so voluntarily, because it is consistent with our mission and because it is the right thing to do. Our mission includes the following:

1. To provide affordable and accessible health insurance to [our members];
2. To assist and support public and private health care initiatives for individuals without health care insurance;
3. To promote integration, efficiency and coherence of a statewide health care system that meets the needs of all Rhode Island residents;
4. To contribute through [our] operations, procedures and investments to the improvement of medical and prevention services delivered in Rhode Island; and
5. To provide affordable and accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed.

See R.I. Gen. Laws § 27-19.2-3.

While BCBSRI fully intends to continue to cooperate with the Commissioner in these efforts, we must retain the ability to do so in a manner that also allows us to be innovative and flexible in contracting with physicians and hospitals, competitive in the marketplace, responsive to the needs of our subscribers, and financially viable.

While BCBSRI does not dispute the role of the Commissioner to weigh in on policy matters such as how the issue of health insurance affordability should be addressed, the proposed amendments to Regulation 2 go too far. As further discussed below, the proposed amendments, particularly those to Section 9(d)(iii), overstate the statutory authority of the Commissioner in that they reflect an attempt by the Commissioner to make, rather than interpret, law. In addition, the proposed amendments unjustifiably usurp the management functions of insurers to determine how best to implement affordability for their particular enterprise. As a result, the proposed amendments as a whole and Section 9(d)(iii), in particular, should be withdrawn.

Authority of the Commissioner to Adopt the Amendments

Administrative agencies are legislative creatures without inherent or common-law powers, and as such possess no ability to take any action that is not specifically granted them in the enabling legislation that creates them, or reasonably derived therefrom.¹ It is outside the purview of the agency "to rewrite or amend statutes that the General Assembly enacted."²

Because all of an administrative agency's powers must derive from powers granted them in the statute that created them, "[i]t is axiomatic that agencies must have 'specific statutory authority for the regulations they promulgate.'"³ Specifically, an agency's regulation must have its basis in the exercise of power granted the agency by the General Assembly, and must fall within the parameters of those statutes that define the powers of the agency.⁴ If there is no "specific statutory authority" for a regulation, "the reviewing court is free to substitute its judgment for that of the agency in deciding whether to enforce the rule."⁵

¹ See Berkshire Cablevision of Rhode Island v. Burke, 488 A.2d 676, 679 (R.I. 1985); F. Ronci Company, Inc. v. Narragansett Bay Water Quality Management District Commission et al., 561 A.2d 874, 881 (R.I. 1989).

² Little v. Conflict of Interest Comm'n, 397 A.2d 884, 886 (R.I. 1979); Rhode Island Federation of Teachers, AFT, AFL-CIO v. Sundlun, 595 A.2d 799, 802 (R.I. 1991); Interstate Navigation Co. v. Division of Public Utilities, 99-5058 (R.I. Super. 2002).

³ Berkshire Cablevision, 488 A.2d at 679, citing Little, 397 A.2d at 886.

⁴ Lerner v. Gill, 463 A.2d 1352, 1358 (R.I. 1983), and cases cited.

⁵ Lerner, 463 A.2d at 1352; Mullins v. Bordeleau, 517 A.2d 600, 603 (R.I. 1986)

There is no statute that explicitly permits the Commissioner to create, mandate, or enforce the affordability standards as he has proposed in Section 9(d)(iii) of Regulation 2. See R.I. Gen. Laws §§ 42-14.5-2, 42-14.5-3. The only mention of generalized affordability standards⁶ appear in Section 42-14.5-3(c), which provides (in relevant part):

The health insurance commissioner shall have the following powers and duties...[t]o establish a consumer/business/labor/medical advisory council [which] shall develop proposals to allow the market for small business health insurance to be affordable and fairer [and] shall issue an annual report of findings and recommendations to the governor and the general assembly and present their findings at hearings before the house and senate finance committees.

Thus, the statute from which the Commissioner derives its authority provides that the Commissioner establishes Health Insurance Advisory Council (“HIAC”), that HIAC develops proposals regarding affordability, and that HIAC reports its findings and recommendations to the governor, general assembly, and the house and senate finance committees. The statute contains no provision requiring or permitting the Commissioner to implement the HIAC proposals absent action by the legislature.

Section 9(d)(iii) of Regulation 2 takes the affordability standards developed by the HIAC and transforms those standards - as well as the exact manner in which those standards must be implemented by all health insurers - into laws. A failure by an insurer to comply with any of the dozens of affordability provisions could be punishable by loss of license, monetary penalties, or other administrative penalties, even though the Legislature has not decided which (if any) of the affordability standards to impose on insurers (as the OHIC Purposes Statute envisions), so that neither the affordability standards – nor the explicit or implicit authority to create and enforce those standards – are included in the Commissioner’s statutory powers and duties or the statutes that the Commissioner enforces.

Not only does the statute contain no provision authorizing the Commissioner to implement the HIAC proposals himself, over the past several years, there have been several bills proposed in the General Assembly that would have implemented some of the proposals developed by the HIAC, but none of those bills were passed. See e.g. 2011 – H5536 and H7228 (mandating certain hospital/insurer contracting provisions, including OHIC oversight of same); 2010 - S2582 and H7544 (mandating OHIC oversight of Commissioner to develop and implement standards for primary care, patient centered medical homes, electronic health records and mandating insurer participation); 2009 Budget Article 8 (amending health insurance rating provisions to mandate that health insurers “be required to establish that it has employed strategies that enhance the

⁶ R.I. Gen. Laws § 42-14.5-3(g)(v) does mention “making health insurance affordable for a selected at-risk population” in analyzing merging the individual and small group markets. This provision does not appear relevant to mandating affordability standards for all payers for all coverages.

affordability of its products.”); 2009 – H5535 (mandating certain hospital/insurer contracting provisions, including OHIC oversight of same).

The Courts consistently have declined “[to] interpret a statute to include a matter omitted unless the clear purpose of the legislation would fail without the implication,” and instead “interpret the General Assembly’s silence as an indication that it did not intend that” the omitted power be granted.⁷ The affordability provision of Section 42-14.5-3(c) does not fail without affording the Commissioner the direct authority to implement affordability provisions; HIAC develops the proposals, the Commissioner and HIAC can present those proposals to Legislature, and the Legislature can decide which, if any, to implement. The statute’s explicit direction that HIAC develop affordability proposals to be made to the Legislature, and the Legislature’s subsequent rejection of these proposals to date, “establishes clear legislative intent that” its failure to grant the Commissioner power to implement and mandate affordability programs on his own was purposeful, and that its silence on this matter should not be read any other way.⁸

The Regulation appears to give two bases to justify imposing the affordability provisions of Section 9(d)(iii), specifically:

- “In discharging the duties of the Office, including but not limited to the Commissioner’s decisions to approve, disapprove, modify or take any other action authorized by law with respect to a health insurer’s filing of health insurance rates or rate formulas under the provisions of Title 27 or title 42, the Commissioner may consider whether the health insurer’s products are affordable, and whether the carrier has implemented effective strategies to enhance the affordability of its products.” (Proposed OHIC Reg. 2, Section 9(b)); and
- “Consumers of health insurance have an interest in stable, predictable, affordable rates for high quality, cost efficient health insurance products. Achieving an economic environment in which health insurance is affordable will depend in part on improving the performance of the Rhode Island health care system as a whole, including but not limited to [the delineated affordability standards.]” (Proposed OHIC Reg. 2, Section 9(a)).

Since the Legislature has actually considered and explicitly rejected amending the statute to include a provision that that insurers be required, as part of their rate filing, to “establish that it has employed strategies that enhance the affordability of its products”, the first rationale is foreclosed as a basis for these provisions. See 2009 Budget Article 8.

⁷ See e.g., State v. Fritz, 801 A.2d 679, 685 (R.I. 2002).

⁸ See Liguori v. Aetna Cas. & Sur. Co., 119 R.I. 875, 884, 384 A.2d 308, 313 (R.I. 1978); R.I. Brotherhood of Correctional v. State, PC 08-4921 (R.I. Super. 4-18-2011).

The second rationale does not derive from any specific statutory authority granted to the Commissioner. Agency regulations must implement the statute as written, and not “inject into them a meaning that would promote what [it] might consider proper public policy”.⁹ Since there are no legislatively-imposed standards surrounding affordability, the rationale set forth in Section 9(a) “would, in essence, grant the agency carte blanche to enact whatever rules regarding [affordability] it deems necessary, with no legislative guidelines to confine and guide [its] power to implement such delegation of legislative authority.”¹⁰ As a result, even if the broad purpose of “[a]chieving an economic environment in which health insurance is affordable” were read as a delegation of authority, it would be an improper delegation.¹¹

Management Prerogative

The Rhode Island Supreme Court repeatedly has held that broad regulatory powers “ordinarily do not include the authority to dictate managerial policy”.¹² The Court differentiates between exercising permissible authority (regulating an industry in order to ensure that its rates are fair and reasonable) and exercising impermissible authority (managing the regulated entity by actually “exercis[ing] the prerogatives of ownership”).¹³ Ordinarily, the decision of what programs to initiate, and how much to spend on those programs, is a function of management, which a regulator should not interfere with absent an adverse impact on rate-payers, “[h]owever benign and well-intentioned the [regulator’s action] may have been”.¹⁴ A mere recitation of the need for reduced costs in the current economic climate is insufficient to meet this burden.¹⁵ Thus, even if the regulator acts to implement a laudable public policy goal, regulation constitutes an unwarranted intrusion upon managerial authority when the regulator “order[s] how [the regulated entity] was to implement its [] plan” or “dictate[s] or prioritize[s] the projects [the entity] might elect to complete”.¹⁶

Here, the amendments to Regulation 2 – particularly Section 9(d)(iii) - mandate not only that insurers take affordability into account, but prescribe the programs they must use, the exact manner in which they implement those programs, the amounts that must be expended, and the priority among those initiatives (as well as other initiatives the insurers

⁹ See Little, 397 A.2d at 887.

¹⁰ See Houghton v. Alexander, P.C. 10-5625 (R.I. Super. 11-29-2010).

¹¹ See id.

¹² Providence Water Supply Board v. Public Utilities Commission, 708 A.2d 537, 543 (R.I. 1998); Hospital Service Corp. v. West, 308 A.2d 489 (R.I. 1973) (applying this principle to regulation of Blue Cross rates).

¹³ See United Transit Co. v. Nunes, 209 A.2d 215, 222 (R.I. 1965); New England Telephone and Telegraph Co. v. Public Utilities Commission, 358 A.2d 1, 13 (R.I. 1976); Blackstone Valley Electric Co. v. Public Utilities Commission, 543 A.2d 253, 255 (R.I. 1988); Providence Water Supply Board, 708 A.2d at 543.

¹⁴ See e.g. Blackstone Valley Electric Co., 543 A.2d at 255; Providence Water Supply Board, 708 A.2d at 543; In re Kent County Water Auth., 996 A.2d 123, 131 (R.I. 2010).

¹⁵ See New England Tel. and Tel., 358 A.2d at 13.

¹⁶ See In re Kent County Water Auth., 996 A.2d at 131.

may want to take independently). The Commissioner imposes these conditions outside of any request for a rate adjustment, and without any individualized determination that the failure of every insurer to implement these programs, as prescribed, will have an adverse impact on ratepayers. Instead, the Commissioner has determined that these programs should be unilaterally imposed on all insurers, regardless of their individual situations, needs, concerns, or affordability strategies as determined by their own internal management, based solely on general economic conditions causing rising health care costs, and its own determination of appropriate public policy to address that issue. The Commissioner's blanket imposition of structure, timing, and payment provisions for all insurers' affordability projects in this manner is exactly the type of unwarranted intrusion upon managerial authority that the Courts have proscribed.

Conclusion

For the reasons described above, enacting the affordability standards developed by the HIAC into law is beyond the statutory authority of the Commissioner, and mandating the exact manner in which those standards must be implemented constitutes an unwarranted intrusion into the management functions of the insurers that he regulates. As a result, the proposed amendments to Regulation 2, and Section 9(d)(iii) in particular, should be withdrawn.

Without limiting the issues raised above, we also offer the following section by section comments:

Section 7 – Encouraging Fair Treatment of Health Care Providers

We recognize that there are no proposed amendments to this section, however, in light of the detailed amendments made to Section 9, we feel it necessary to comment on this section as well. In addition to generally ensuring the fair treatment of providers, this section authorizes the Commissioner to take the insurers relationships with providers into consideration when approving or denying an application or filing. When the regulation is read in its entirety, it becomes unclear what an insurer may have to do to meet the expectations of the Commissioner under Section 7 in addition to those requirements in Section 9. It appears that portions of this section – at least those related to considerations in relation to filings – must be deleted in light of the amendments to Section 9. Otherwise, this section must be modified to provide more objective criteria that, in addition to those set forth in Section 9, will be used to evaluate a filing.

Sections 9(a)(iv), (b), and (c)(vi) – Determining Whether Products are Affordable

The addition of these sections is overly broad, arbitrary, and fails to provide a meaningful standard that insurers can ascertain and address in a filing. The language introduces a level of subjectivity that virtually ensures that an insurer will be unable to demonstrate

affordability. It creates a virtual moving target, and provides no advance notice or meaningful opportunity to comment. Standards used to evaluate a rate filing must be objective, clearly defined, measurable, and consistent across all carriers; they must also be promulgated in accordance with the Rhode Island Administrative Procedures Act (“APA”) (R.I. Gen. Laws Chapter 42-35) and must be consistent with the statutory framework for reviewing rate filings, that is, that the filing be “. . . consistent with the proper conduct of its business and with the interest of the public.” (See R.I. Gen. Laws §§ 27-19-6, 27-20-6, and 42-62-13.) These sections provide none of the protections that the APA is intended to provide, therefore, we recommend removing these sections entirely.

Section 9(d)(iii)(A)(1) through (3) – Financial Support for Primary Care Services

It is our understanding that this section is intended to memorialize the Commissioner’s efforts to date regarding primary care spend. Again, BCBSRI has voluntarily supported and cooperated with the Commissioner’s efforts in this regard for several years. Indeed, we have been doing this work since 2005, well before the Commissioner and the HIAC adopted the most recent “affordability principles” in 2009. We believe that the 2009 principles were the direct result of our work and reflect the intent of both the Commissioner and HIAC to have the other carriers do the same. With that said, we have also raised concerns regarding the level of spend being requested by the Commissioner and the sustainability of that spending. As a result, while we generally support the concept, we object to the inclusion of this section in the regulation for the following reasons:

1. Annual review is necessary to ensure that the increasing spend is appropriate and actually reducing costs. If the current rate of increase in Primary Care spending continues, the primary care reimbursement in Rhode Island will be among the highest – if not *the* highest – in the country. An objective measure must be established in order to determine the effectiveness of the required spending and that standard must be met in order for additional spend to be required. One objective standard may be to review the reimbursement in Rhode Island with regional and/or national trends in order to ensure that the increases proposed by the Commissioner do not outpace those trends. We recommend that an actuary be engaged to review the spending, trends, and related results to ensure that the increasing spend will result in reduced cost.
2. The scope of spending that is counted towards meeting this goal is too narrow. While BCBSRI recognizes the importance of appropriate compensation for primary care providers, we also support programs that improve the interface between specialists and primary care providers, the use of practice coaches, enhancement of reporting tools, and other services related to the management of primary care practices. We believe these investments and payments must be measured and attributable to the spending goal.

3. Section 9(d)(iii)(2) requires detailed reporting of medical and primary care spend, however, the reporting format is not provided. Similarly, Section 9(d)(iii)(3)(I)-(II) requires submission of an annual investment plan and quarterly investment plan forecast, in a format to be determined. It appears that in both instances the reporting will be at a sufficient level of detail that a competitor in the market place or a provider (or set of providers) could ascertain the contracted rates between an insurer and provider or other proprietary data. BCBSRI objects to the level of detail required to the extent that the reporting will be made available publicly.

First, we believe this level of detail consists of proprietary and confidential trade secret, commercial, and/or financial information which is not publicly disclosed by BCBSRI and is, therefore, exempt from public disclosure pursuant to R.I. Gen. Laws § 38-2-2(4)(B) and protected under the Uniform Trade Secrets Act (R.I. Gen. Laws Ch. 6-41).

Second, the publication of this information by the Commissioner could have the effect of permitting – even encouraging – collusion among health plans and among providers. Such conduct is per se illegal under antitrust laws and is bad public policy. It is also likely to result in higher prices. We have previously briefed this issue for the Commissioner in a submission dated April 21, 2008.

4. Section 9(d)(iii)(3) orders each health insurer to participate in a public planning process “to determine the most appropriate usage of the additional monies to be spent in the next calendar year . . .” As discussed in the introductory comments, this provision purports to vest in the Commissioner the right to determine how each insurer uses its staff and financial resources. It essentially puts our contracting and payment policies in the hands of the public, and replaces the judgment of our management team with that of not only the Commissioner, but unelected, unappointed and unnamed individuals who have no responsibility (statutory or otherwise) for or knowledge of managing an insurance company.
5. The program as designed by the Commissioner was set to sunset effective December 31, 2014. If adopted, this section should be amended to reflect that sunset date.

Section 9(d)(iii)(A)(4) – Collecting usual source of care

BCBSRI supports the concept of having an individual identify, at the time of enrollment, their primary care provider. With that said, it will take time for this information to be gathered. In addition, we recognize that an individual may choose not to identify a

primary care provider at enrollment, and may choose not to provide such information at any other time. Similarly, individuals change their primary care provider at various times for various reasons and may do so without informing us. As a result, this section should not act to require an individual to name a primary care provider as a condition of enrollment in a plan. We would like this section to ensure that insurers have maximum flexibility in collecting and utilizing this information.

As written, this section appears to allow a member to select a primary care provider that is not contracted with the insurer. We would have difficulty in identifying and reporting on these non-participating providers because we would not have their national provider identifier, contact information, or other information by which to identify and track them. Therefore, we request that this section be modified to specify that the primary care physician be contracted with the insurer. We believe this is consistent with the provisions of the Patient Protection & Affordable Care Act which provides:

“If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires *or provides for* designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate *any participating primary care provider* who is available to accept such individual.” (Public Health Services Act, § 2719A(a), emphasis added.)

With that issue in mind, we propose the following modifications to this section:

1. Section 9(d)(iii)(A)(4) should be modified to read as follows (underlining represents added text, strikethrough represents deleted text):

“Consistent with the development of the incentives established in subdivision (d)(ii), for plan years commencing after October 31, 2011 each health insurer shall collect information on the subscriber’s and dependent’s usual source of care at the time of enrollment and annually thereafter from all commercially insured subscribers and any dependents that reside in Rhode Island, consistent with the following standards and procedures:”

We also suggest adding the following language to this section:

“The subscriber and/or their dependents may designate any primary care provider who is contracted with the insurer and who is available to accept such individual.”

2. Section 9(d)(iii)(A)(4)(I) should be modified to read as follows (strikethrough represents deleted text):

“Annual updating of this information may occur either at the time of contract renewal or during an annual updating period for all subscribers, as selected by the insurer. Information at enrollment may be collected in the format and means deemed most efficient and effective by the insurer, ~~but shall include statements on the desirability of having a usual source of care, and on the relationship if any between the information provided and the subscriber’s insurance benefits.~~”

3. Section 9(d)(iii)(A)(4)(II) should be modified to read as follows (underlining represents added text, strikethrough represents deleted text):

“Once the information is collected, the insurer shall record the name of the primary care physician or primary care practice in the electronic enrollment and eligibility record of each subscriber and dependent. The insurer ~~shall~~may use this information as appropriate for purposes including but not limited to benefit plan design and adjudication, provider reporting, provider and patient communications and provider payment.”

4. Section 9(d)(iii)(A)(4)(III) should be modified to read as follows (underlining represents added text, strikethrough represents deleted text):

“The insurer shall report to the OHIC by April 1 of each year in correspondence from senior management its efforts in the previous 12 months at collecting the information required by this subsection (ed)(4), ~~measures of the information’s comprehensiveness and accuracy, and the insurer’s plans for improving both in the coming year.~~”

5. We note that this Section uses the terms “primary care physician” and “primary care practice”, neither of which is defined. We recommend that the term “primary care provider” (defined at proposed Section 9(d)(iii)(A)(5)(III)) be used in lieu of these undefined terms.

We note that the General Assembly considered legislation in the 2010 session regarding the designation of a primary care provider (H 7599 and S 2579) and is again considering such legislation this year (S 0874). It is our understanding that this legislation may have been introduced at the request of the Commissioner. As noted in the introductory comments, we believe the very consideration of these bills by the General Assembly indicates that the Commissioner lacks the authority to adopt this section.

Section 9(d)(iii)(B) – Patient Centered Medical Home Initiative

Again, BCBSRI is an avid supporter of Patient Centered Medical Homes (PCMH), we have actively participated in the Chronic Care Sustainability program (“CSI-RI”), and

have provided significant financial and staff support to CSI-RI. Despite that support, we object to this section.

First, we note that the General Assembly considered legislation in the 2010 sessions regarding patient centered medical homes (H 7544 and S 2582) and is again considering such legislation this year (H 5276 and S 0070). It is our understanding that this legislation may have been introduced at the recommendation of the Commissioner. As noted in the introductory comments, we believe the very consideration of these bills by the General Assembly indicates that the Commissioner lacks the authority to adopt this section.

In addition, we object to this section based on the following:

1. As discussed in the introductory comments, this provision purports to vest in the Commissioner the right to determine how each insurer uses its staff and financial resources, substituting the Commissioners judgment for that of management. It essentially puts our contracting in the hands of the public, and replaces the judgment of our management team with that of not only the Commissioner, but unelected, unappointed and unnamed individuals (the “Collaborative”) who have no responsibility (statutory or otherwise) for or knowledge of managing an insurance company.
2. It fails to establish an objective measure by which it will be determined whether the program has been successful and whether it should continue. The CSI-RI program must not be continued indefinitely, or expanded, unless such continuation or expansion is supported by data that shows a demonstrable reduction in cost and/or improvement in quality. The regulation provides no timeframe or other mechanism for a study to be conducted and information to be published and provides no parameters for the program to be disbanded in the event the data fails to support an on-going initiative.
3. It does not provide for insurers to develop their own programs that may achieve the goals of this section through an alternative means. For example, BCBSRI has entered into contracts with more than 120 physicians who have agreed to adopt a patient centered medical home method of care. We must retain the ability to modify the program as appropriate based upon results.

Section 9(d)(iii)(C) – Electronic Health Record Incentive Payment

We generally support the goals of this section. BCBSRI is already moving toward adoption of the meaningful use standard as defined by the Centers for Medicare and Medicaid Services (“CMS”). We note, however, that the CMS standard is not effective until July 2012 and that the program is voluntary. We recommend that the regulation

adopt a timeframe consistent with the CMS regulations. In addition, we believe the incentive program should sunset in 2016.

Section 9(d)(iii)(C)(3) requires submission of an annual plan for electronic health record incentives. No format is specified. It is possible that the format of the plan will be at a sufficient level of detail that a competitor in the market place could ascertain the contracted rates between an insurer and provider or other proprietary data. BCBSRI objects to the requirement to the extent that the reporting will be made available publicly on the grounds that this level of detail may consist of proprietary and confidential trade secret, commercial, and/or financial information which is not publicly disclosed by BCBSRI and is, therefore, exempt from public disclosure pursuant to R.I. Gen. Laws § 38-2-2(4)(B) and protected under the Uniform Trade Secrets Act (R.I. Gen. Laws Ch. 6-41).

Section 9(d)(iii)(D) – Cost-effective Contracting with Hospitals

In reviewing Section 9(d)(iii)(D)(2), we note a material omission which we believe needs to be corrected (underlining represents added text):

“Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index (“Index”), for all contractual and optional years covered by the contract. The Index applicable to the new contract year will be based on the most recent actual Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year.”

We note that the General Assembly has considered legislation in at least the last three sessions regarding hospital contracting and is again considering such legislation this year. (See 2009: H 5960, H 5535, and S 0186; 2010: H 7648, H 7228, S 2540, and H 7500; and 2011: S 0870, S 0873, H 5305, and H 5536.) In addition, these conditions (as adopted in the 2010 rate decisions of the Commissioner for all insurers) have been the subject of litigation. As a result, while we are supportive in concept, we are concerned that this is fraught with the potential for litigation from various hospitals and thus unlikely to be consistently applied.

Section 9(f) – Review of Payment Strategies

As noted above, the responsibilities of the HIAC is established by Rhode Island law. This section expands the responsibilities of the HIAC beyond that statutory framework. Specifically with respect to provider relationships, the HIAC is to “. . . obtain information and present concerns of . . . medical providers affected by health insurance decisions . . .”

Mr. Olson
May 3, 2011
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and “. . . assess views of the health provider community relative to insurance rates of reimbursement, billing and reimbursement procedures, and the insurers' role in promoting efficient and high quality health care.” The HIAC is charged with “. . . issu[ing] an annual report of findings and recommendations to the governor and the general assembly and present[ing] their findings at hearings before the house and senate finance committees.” (R.I. Gen. Laws § 42-14.5-3(c)) As written, this section shifts the responsibilities in this regard to require reporting to the Commissioner, and appears to give the Commissioner discretion whether to adopt such recommendations. This is not supported by statute, therefore, we object to the changes set forth in this Section.

Thank you for the opportunity to submit these comments. If you have any questions, please do not hesitate to contact me at 459-1287.

Sincerely,

A handwritten signature in black ink, appearing to read "Monica A. Neronha". The signature is fluid and cursive, with the first name "Monica" being the most prominent part.

Monica A. Neronha
Vice President, Legal Services

cc: Michele B. Lederberg, Esq.



Hospital Association of Rhode Island
100 Midway Road – Suite 21
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(401) 946-7887 Fax (401) 946-8188

Edward J. Quinlan
President

May 4, 2011

RECEIVED

MAY 04 2011

Health Insurance
Commissioner

Mr. Christopher F. Koller
Health Insurance Commissioner
Office of the Commissioner
115 Pontiac Ave, Building #69, First Floor
Cranston, RI 02920

Dear Mr. Koller:

The Hospital Association of Rhode Island (HARI) submits this letter to you to express our concerns regarding rules promulgated by the Office of the Health Insurance Commissioner on the powers and duties of the commissioner. Our primary concern relates to potential future bypasses of the state's Administrative Procedures Act (42-35 of the General Laws of Rhode Island).

Section 9 of Office of the Health Insurance Commissioner Regulation 2 – Affordable Health Insurance – is proposed to be expanded to include restrictions on contracts between health insurers and hospitals. These new restrictions include limits on annual rate increases for hospital services, prescribe payment methodology terms of insurer and hospital contracts, and place additional requirements on health insurer contracts with hospitals.

While we have questioned the authority of the commissioner to place terms and conditions on the contracts between private parties, we specifically object to a proposed regulation that states:

“Such contracts shall include such other terms as the Commissioner determines, after notice and an opportunity to be heard, will enhance the cost-effective utilization of appropriate services.”

It is our view that “notice and opportunity to be heard” could be construed to circumvent the rule-making requirements of the Administrative Procedures Act which specify the following:

1. Prior to the adoption, amendment, or repeal of any rule the agency shall give at least thirty (30) days notice of its intended action. The notice shall include a statement of either the **terms or substance** of the intended action or a description of the subjects and issues involved, and of the time, place, and the manner in which interested persons may present their views.
2. Afford all interested persons reasonable opportunity to submit data, views, or arguments, orally or in writing. In the case of rules, opportunity for oral hearing must be granted if requested by twenty-five (25) persons, or by a governmental subdivision or agency, or by an association having not less than twenty-five (25) members.

Mr. Christopher F. Koller
May 4, 2011
Page 2

3. Demonstrate the need for the adoption, amendment, or repeal of any rule in the record of the rulemaking proceeding.
4. No rule adopted is valid unless adopted in substantial compliance with this section, but no contest of any rule on its face on the ground of noncompliance with the procedural requirements of this section may be commenced after two (2) years from its effective date.
5. When refiling rules and regulations, agencies may change the format of existing rules without any rule-making action by the agency in order to comply with the format for filing specified by the secretary of state so long as there is no **substantive** change to the rule.

We are very concerned that any additional terms or provisions the commissioner deems appropriate to enhance cost-effective utilization of services could be implemented without filing new proposed rules in accordance with the Administrative Procedures Act. These would be substantive changes that are clearly governed by the act.

Accordingly, we would recommend that section 9(d)(iii)(D)(7) be amended to read as follows:

“Such contracts may include additional terms to enhance the cost-effective utilization of appropriate services but only if such terms shall have been promulgated by the Commissioner after compliance with the provisions of Sections 42-35-3 and 42-25-4.1 of the general laws.”

Sincerely,



Edward J. Quinlan
President

cc: Gov. Lincoln D. Chafee
Mr. Patrick Rogers
Mr. Richard Licht
Mr. Steven M. Costantino

April 27, 2011

Commissioner Christopher Koller
Office of the Health Insurance Commissioner
1511 Pontiac Avenue - Building 69-1
Cranston, RI 02920

RECEIVED

MAY 04 2011

**Health Insurance
Commissioner**

Re: Proposed Regulation 2 – Powers and Duties of the Office of the Health Insurance Commissioner

Dear Commissioner Koller:

I am writing on behalf of Tufts Health Plan to offer written comments on the proposed amendments to Office of the Health Insurance Commissioner Regulation 2 - Power and Duties of the Office of the Health Insurance Commissioner.

Since 1979, Tufts Health Plan has been committed to providing a higher standard of health care coverage and to improving the quality of care its network providers deliver for every member. Tufts Health Plan's Health Maintenance Organization (HMO) and Point of Service (POS) plans are ranked number two according to the National Committee for Quality Assurance's (NCQA) health insurance plan rankings and its Medicare Advantage plan, Tufts Health Plan Medicare Preferred, is ranked number four in the nation.

The proposed changes to Regulation 2 primarily enhance the authority of the Health Insurance Commissioner to consider the efforts of health plans towards increasing the affordability of health insurance as a consideration for rate factor filings. We have supported and participated in the past initiatives developed by the Office of Health Insurance Commissioner, and we share the goals of greater efficiency and sustainable costs for the state's health care system.

Section 9 – Affordable Health Insurance

Section 9 (iii) (A) would require continued participation in the initiatives known as the Affordability Standards. Investments in programs such as the Chronic Care Sustainability Initiative (CSI-RI), payments to providers for electronic health records, and increased spending on primary care would be considered by the Commissioner when evaluating a health plan's annual rate factor filing. As a carrier doing business in Rhode Island, we have participated in the planning and investment activities included in the Affordability Standards since entering the market in 2009. While we continue to be supportive of these initiatives, appropriate measurement efforts must be undertaken.

These programs are ultimately paid for by our subscribers and we must ensure that they result in positive return to the system. Additionally, given our small membership,



accurately forecasting these investments can be difficult. Particularly with regard to the CSI-RI program, which ties payments to participating members, fluctuations in membership can significantly impact total investments throughout the year. We would suggest a membership threshold, below which a carrier would be exempt from the requirements of Affordability Standards section of the regulation, or would receive some relief from the planning and reporting process each year.

Section 9 (iii) (D) includes a requirement that carriers comply with six conditions in all hospital contracts. Compliance with these conditions would also be considered by the Commissioner when reviewing rate factor filings. What we are trying to achieve with these conditions is important. We believe that it is important to establish a set of goals and objectives, as we attempt to control the rising cost of health services. We support the incentives described in "Condition #3" relating to bonus payments and will continue to work with the provider community to establish meaningful incentive programs that result in improved outcomes. However, given the requirement that these incentive payments must allow a hospital to receive at least a 2% increase in revenue, these agreements can have a significant impact on the overall cost of the contract. We would suggest the Commissioner provide more detailed guidance on appropriate measures that will achieve both quality improvement as well as cost savings. While we are supportive of pay-for-performance incentives as a means to drive increased quality and efficiency, we feel that these payments should always be tied to improved outcomes and produce net cost savings for Rhode Island employers and residents.

Tufts Health Plan appreciates the opportunity to comment on the proposed Regulation 2. If you have any questions, please do not hesitate to contact me by email at Kristin_Lewis@tufts-health.com.

Sincerely,

A handwritten signature in cursive script that reads "Kristin Lewis".

Kristin L. Lewis
Vice President, Government Affairs, Public Policy
& Compliance
Tufts Health Plan

RECEIVED

MAY 04 2011

Health Insurance
Commissioner



Lifespan

May 4, 2011

External Affairs

The Coro Building
167 Point Street
Providence, RI 02903

Tel 401 444-3720
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Email mmontella@lifespan.org

Mark Montella
Senior Vice President

Christopher F. Koller
Health Insurance Commissioner
1511 Pontiac Ave
Building #69, First Floor
Cranston, RI 02920

Dear Commissioner Koller,

Thank you for the opportunity to submit the following comments regarding the Health Insurance Commissioner's ("OHIC") proposed regulatory changes to Insurance Regulation 2. We share the Commissioner's concerns about the continued availability of affordable health care for all Rhode Islanders. These concerns over affordability lead us, despite concerns with OHIC's authority to implement a cap on hospitals rates, to sign a contract with Blue Cross Blue Shield of Rhode Island, in the summer of 2010 in conformance with his edict. Despite this action we have always been concerned at the speed at which OHIC is attempting to get to CPI inflationary rate for hospital payments.

Upon review of the proposed regulatory changes to the Regulation 2 we respectfully object to the proposed changes in their entirety. The proposed amendments go well beyond the statutory authority of RIGL 42-14.5-3 which identifies the Powers and Duties of the Office of the Health Insurance Commissioner.

While OHIC purports to makes these amendments to Section 9 of Regulation 2, "Affordable Health Insurance" in order to identify the purposes and general goals, as well as clarify the role of OHIC with respect to health insurance rate filings, and identify specific payment strategies for health insurers for consideration when determining cost effective utilization of appropriate services but in fact the proposed amendments broadens the scope of OHIC's authority well beyond the statutory limits. We respectfully request that OHIC withdraw the proposed amendments. We presume that had the General Assembly wanted to include the powers OHIC is attempting to implement through regulations they would have included that authority when they created the enabling legislation.

Lifespan is committed to providing high quality, efficient care to all Rhode Islanders; we thank you for the opportunity to provide comments on the proposed changes to Regulation 2.

Sincerely,

Mark Montella
Senior Vice President

CARE NEW ENGLAND

BUTLER HOSPITAL • KENT HOSPITAL • WOMEN & INFANTS HOSPITAL
CARE NEW ENGLAND HOME HEALTH • CNE WELLNESS CENTERS

May 3, 2011

Christopher F. Koller
Health Insurance Commissioner
Office of the Commissioner
1511 Pontiac Avenue, Building #69, First Floor
Cranston, RI 02920

RECEIVED

MAY 05 2011

Health Insurance
Commissioner

Dear Mr. Koller:

Care New England Health System ("CNE") has reviewed the Office of the Health Insurance Commissioner's ("OHIC") proposed regulatory changes to Insurance Regulation 2 ("Proposed Changes") and objects to the Proposed Changes. The Proposed Changes, as they are currently written, are overly broad, unnecessarily intrusive into the management of health care providers and insurers, reduce economic efficiency, and exceed OHIC's delegated authority under Titles 27 and 42 of the Rhode Island General Laws.

The Proposed Changes amount to an excessive arrogation of unfettered discretion beyond the limited power delegated to OHIC by the General Assembly. The effect of the Proposed Changes is to bestow upon the Commissioner the authority to interfere with the dealings between providers and insurers as he sees fit. The Proposed Changes go so far as to permit the Commissioner to do whatever he believes is desirable in his opinion. For instance, the Proposed Changes to Section 9(c)(vi) purport to empower the Commissioner to consider "[a]ny other relevant affordability factor, measurement or analysis determined by the Commissioner to be necessary or desirable to carry out the purposes of this Regulation." Under Section 9(d)(iii)(D)(7), the Proposed Changes purport to empower the Commissioner to require in all contracts between insurers and providers "such other terms as the Commissioner determines, after notice and an opportunity to be heard, will enhance the cost-effective utilization of appropriate services." Such undefined and unrestrained authority in one person is ill-advised and misguided, not to mention unauthorized by the General Assembly.

The General Assembly afforded OHIC with jurisdiction to enforce Titles 27 and 42 of the Rhode Island General Laws with respect to health insurance. But jurisdiction over health insurance does not equate to unfettered and unchecked power. The "powers and duties" of OHIC are expressly enumerated in R.I. Gen. Laws § 42-14.5-3. None of those powers and duties allows OHIC to carry out the functions purported in the Proposed Changes. Indeed, neither Title 27 nor Title 42 of the Rhode Island General Laws confers such authority. For instance, the Proposed Changes under Section 9(d)(iii) impose unwarranted conditions and restrictions on all contracts between insurers and providers. R.I. Gen. Laws § 27-19-7, however, specifically authorizes insurers to enter into contracts with providers to establish the rates that providers will charge to insurers for hospital services that providers render to insurers' subscribers. R.I. Gen. Laws § 27-19-7(a); *see also* R.I. Gen. Laws § 27-19-5(a). Significantly, the statute places no condition or other prohibition on the rate agreements that insurers may enter into with providers.

The Commissioner, by way of regulation, cannot grant himself unfettered discretion to make certain decisions that the General Assembly did not delegate to him. Doing so would create

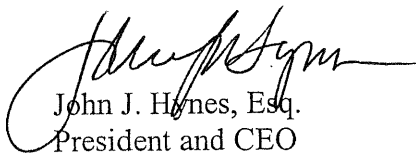
significant unintended consequences, including, among other things, reduced economic efficiency. Essentially, the Proposed Changes would give the Commissioner a seat at every contract negotiation between an insurer and provider and condition every contract between an insurer and provider upon the blessing of the Commissioner. The result would make complex negotiations between insurers and providers impracticable and unworkable, at best. Providers and insurers would ostensibly reach agreement after protracted negotiations, only to have the Commissioner interfere and unilaterally dictate his desires be included in the agreement and whether the agreement is acceptable in his opinion. This uncertainty and unpredictability increases economic risk surrounding such transactions and leads to increased transaction costs and economic inefficiency.

OHIC is not clarifying its "powers and duties" in the Proposed Changes. Rather, it is expanding the scope and reach of its authority beyond that of its enabling statutes. It is the General Assembly's responsibility, however, to enact legislation authorizing OHIC to act. The Rhode Island Supreme Court has made clear that when governmental agencies construe their own enabling provisions setting forth the scope and reach of its jurisdiction and powers, they have "a tendency to swell, not shrink, and are likely to have an expansive view of their mission." *In re Advisory Opinion to the Governor*, 732 A.2d 55, 60-61 (R.I. 1999). In this instance, the General Assembly has not authorized OHIC to carry out the powers purported in the Proposed Changes.

It would appear that OHIC is attempting to use amendments to Regulation 2 to individually legislate healthcare payment reform and grant itself authority akin to that of a public utility to set rates. What is worse, it is doing so without any of the safeguards and protections provided to those utilities through appropriate lawmaking in a legislative body. OHIC is a creation of the General Assembly and it is the role of the General Assembly to define the purposes of that office and empower it to act. Article VI of the Rhode Island Constitution places the legislative power in the General Assembly because the General Assembly is designed to represent the will of the people in establishing laws, not just the will of one person in power. We at Care New England recognize and acknowledge that payment reform must come, but it should not and cannot be made by one person and bypass the democratic process of enacting law through the General Assembly and all of the protections that affords to the interests of everyone affected by those reforms.

Thank you for your attention to CNE's concerns. Please call if you have any questions or would like any additional information.

Very truly yours,



John J. Hynes, Esq.
President and CEO

cc: Lincoln D. Chafee, Governor
Gordon D. Fox, Speaker of the House
M. Teresa Paiva Weed, President of the Senate
Nicholas A. Mattiello, House Majority Leader
Dominick J. Ruggerio, Senate Majority Leader
Steven M. Costantino, Secretary, Executive Office of Health & Human Services